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ABSTRACT

The potential influence of cognitive-behavioral theory on counselor preparation is an important aspect to consider in training counselors and therapists. To determine the effects of self-instruction and the knowledge of how to develop a clinical hypothesis on master's degree counselor trainees, two studies were conducted. In the first study, entry level counselor trainees completed a counseling questionnaire and were assigned to one of four treatment conditions on the basis of their responses: self-instruction strategy only; clinical hypothesis knowledge only; a combination of both self-instruction and clinical hypothesis knowledge; and placebo control. Participants in each condition observed a six-frame videotape of a client problem and, during pauses between each frame, received live instruction in self-instruction strategy or the elements of clinical hypothesis formulation. Next, participants applied the learned skills between pauses in viewing an eight-frame videotape. In study 2, high-level graduate students proceeded exactly as in study 1 except for receiving written instructions. Data analyses of the responses of participants in all conditions is yet to be performed. Earlier pilot studies, however, suggest significant gains for each treatment condition. (The appendices provide transcripts of both the eight- and six-frame videotapes, the thought listing instrument, the counseling questionnaire, and the instructional scripts for the self-instructional strategy and the hypothesis formulation.) (AG)

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Internal Dialogue in Counseling: Research in Training Counselors and Other Helping Professions

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Internal Dialogue in Counselor Training

Cognitive-behavioral theorists share in the notion that a persons internal dialogue is directly related to how that person problem solves (Merluzzi, Glass, and Genest 1981). While most cognitive-behavioral research has focused on counseling and psychotherapy, the potential influence of cognitive-behavioral theory on counselor preparation is becoming an important aspect to consider in training counselors and therapists. That is, it is as important to understand how a counselor in training cognitively processes input from a client and then elaborates on that information as it is for a client who is going through a similar process to learn how to solve a personal problem.

Three assumptions commonly associated with the cognitive-behavioral approach and which seem to transfer easily to counselor education are: 1) adaptive and maladaptive behaviors are developed through cognitive processes, 2) these cognitive processes can be assessed and changed through social learning techniques, and 3) diagnosticians/educators need to functionally analyze cognitive processes and then arrange learning conditions to alter cognitions and behaviors.

Several strategies such as self-observation, self-modeling and self-instruction have been used as interventions to enhance the desired learning. In the two pilot studies that follow, self-observation and live modeling are used although modeling is not a separate condition. Study I is designed to determine the effects of self-instruction and knowledge of developing a clinical hypothesis for entry level masters degree trainees. Study II is designed to investigate the effects of substituting a written format for the live model format.

Methodology

Subjects

The respondents involved in the research project are enrolled in the graduate program of the Counselor Education Department at the Bloomington and Indianapolis campuses of Indiana University. Since the level of training is an independent variable in this project, students in pre-practicum (low level), practicum (intermediate level), and internship (high level) are included. Their ages are approximately in the mid-twenties range and the sex ratio is approximately two females to one male. Participation in the project is voluntary, but instructional time is utilized to maximize participation and motivation of all students.

Materials

Two videotapes, one set up with six frames and one with eight frames, present the client stimuli to the respondents. Each videotape is a series of vignettes about a real-life problem portrayed by a coached client; a white male talks in the six-frame tape and a white female talks in the eight-frame tape. For a transcript of client statements see Appendices A and B. The videotaped client statements range from less than a minute to one and a half minutes per frame. The tape plays continually with each frame followed by two minutes of blank tape to allow time for presentation of the treatment, or to allow time for thought listing by the respondents during the pre-test and post-test assessment.

Instruments

The Thought-Listing Technique, as developed and tested by Cacioppo and Petty (1981), was used by participants to self-report their responses to the client stimuli videotape. It provides respondents with more than enough empty "boxes," ten "boxes" per page, in order to list one thought per box. For the six-frame videotape six pages are needed and for the eight-frame videotape eight pages are required. Appendix C illustrates this scheme.

According to Cacioppo and Petty (1981), the Thought-Listing Technique has proven to be a reliable and valid measure of cognitive responses in previous research on attitude change and social-evaluation anxiety. The procedure does not appear to be reactive. That is, the procedure does not affect the responses to the task under investigation. This technique taps thoughts that mediate affective responses rather than post hoc rationalizations for these responses. Thought-Listing accomplishes this by adhering to strict guidelines, which are: (1) accessing responses while still in short-term memory, (2) eliminating probing into the responses, (3) asking for descriptions and not causes or motives of responses, (4) motivating for honest and careful reporting (Michenbaum & Camaron, 1981).

The Counseling Questionnaire, a pre-treatment screening test, is used to stratify respondents according to their prior knowledge and strategy constructs pertaining to clinical hypothesis formulation (see Appendix D).

A brief retrospective self-report questionnaire is used to allow the participants to describe their clinical hypothesis formulated about the client which appeared on the videotape. It simply asks the participant to advance their assessment of the client's problem(s) and their rationale for such an assessment (see Appendix E).

Treatments

Two independent treatments are utilized in the study under five different conditions. The two treatments are clinical hypothesis knowledge and self-instruction strategy. Outlined below is the essential treatment content provided the participants for the various conditions.

Clinical Hypothesis Knowledge. This treatment is, in part, derived from Holloway and Wolleat's (1981) elements that lead to an accurate clinical hypothesis and requests the trainee to identify the following:

A. The client's major problem or theme.

B. The significant internal (inferential personal characteristics) and external (kinesthetic behaviors, social contexts, relationships) factors of the client.

C. The connection between these internal and external factors.

D. The possible cognitive, affective, and behavioral aspects of the problem, and the extent to which each of these is an integral part.

In their research of counselor trainees, Holloway and Wolleat discovered that the ability to differentiate bits of information and to integrate these bits of chosen information led to a better overall understanding of the client's problems. They suggest that trainees may need a model for different types of information that could potentially aid in their tests of clinical hypotheses. The treatment outlined above is intended to provide a systematic means of teaching a trainee to judiciously select and use client information effectively and efficiently.

Self-Instruction Strategy. This treatment is based on Michenbaum's (1980) Self-Instruction Model involving the following elements of an effective covert thinking strategy and requests the trainee to:

A. Ask questions about the nature of the counseling task needing to be performed.

B. Answer those questions posed through cognitive rehearsal.

C. Guide the task performance with self-instructions about what needs to be and what has been accomplished.

D. Use internal dialogue coping skills to deal with difficulties, e.g. frustration or errors. This dialogue suggests the trainee:

1. Try something different when blocked from the goal.
2. Use frustration as a source of energy for creativity.
3. Slow down, take a brief rest.
4. View errors or mistakes as good information for future attempts.

E. Give positive self-reinforcement throughout the process, i.e. verbal and non-verbal "strokes."

Research suggests that giving counselor trainees a cognitive strategy about the critical thinking that accompanies clinical skills facilitates their performance (Richardson & Stone, 1981). This strategy involves the predicting, planning, and checking that proceeds counseling tasks and is termed metacognition (Michenbaum & Asarnow, 1980). One method for teaching cognitive strategy is Michenbaum's Self-Instruction Model as outlined above.

Procedures

This investigative process has involved several preliminary studies (Froehle, 1981; Froehle, Kurpius & Maniai, 1981), and currently consists of two concurrent, ongoing designs.

Study I. In the major study, pre-practicum (low level) and practicum (intermediate) graduate students first complete a pre-treatment screening test, the Counseling Questionnaire (see Appendix D) to determine prior awareness. The instrument is scored according to the criteria of Holloway & Wolleat's elements of an accurate clinical hypothesis and Michenbaum's self-instruction strategy. Once scored participants are stratified according to prior awareness of the treatment content and then randomly assigned to one of four treatment conditions.

Then the four treatment conditions proceed as described below:

(1) Self-Instruction Strategy Only Condition. Prior to viewing the videotape, a description of the self-instruction strategy is presented to the trainees by a live female model. Next, participants observe each of the six vignettes of the six-frame videotape and receive the treatment content during a two minute blank tape recording between each frame. To implement this, the live model demonstrates the self-instruction strategy by thinking aloud about the counseling task, asking and answering questions, giving herself positive

reinforcement, and coping with difficulties during each pause during the six videotape client statements (see Appendix F for script). Then, the six-frame videotape is replayed and the trainees practice the strategy according to the following steps:

A. Participants attempt to perform the demonstrated strategy during the blank tape play in response to the first videotape vignette while the live model quietly repeats the steps.

B. Participants practice the task again during the pause after the second segment while instructing themselves aloud as the livel model did.

C. Participants perform the strategy during the pauses after the third and fourth segments while whispering to themselves as needed.

D. Participants self-instruct themselves in the strategy covertly during the pauses after the fifth and sixth segments.

(2) Clinical Hypothesis Knowledge Only Condition. Participants observe each segment of the six-frame videotape and receive the treatment content in the pauses between each frame. A live instructor presents the elements of a good clinical hypothesis formulation during the pauses between each of the six videotape client statement segments. This modeled formulation includes internal and external factors, their interacting relationship, and the cognitive, affective, and behavioral elements of the client's problem.

(3) Combination of Both Self-Instruction Strategy and Clinical Hypothesis Knowledge. Participants observe each segment of the six-frame videotape and receive the treatment content in the pauses between each frame which proceeds just like the strategy only condition. For the exact content of the self-instruction strategy and clinical hypothesis demonstrated by the live model refer to Appendix G.

(4) Placebo Control Condition. Participants view a film on another aspect of self-observation, Kagan's (1969) Interpersonal Process Recall. This intervention equals the amount of time as the preceding three conditions, involves some talking aloud via group discussion, and is also guided by a live instructor. These participants do not view the six-frame videotape.

Post Test. Next, participants are asked to apply the treatment they received to a new case, the eight-frame videotape. They are given directions in how to fill-out the thought-listing instrument. The directions ask them to report their thinking, to be honest, to use phrases, and to ignore spelling and punctuation. They then observe the client stimuli statements presented in each segment, and respond by listing their thoughts during the pauses between the eight segments. Immediately after responding to the entire eight-frame videotape, the participants complete the retrospective self-report questions about their clinical hypothesis concerning the client's problem(s) and their rationale for such hypotheses. A six week follow-up post-test will be conducted to determine duration effects for each of the treatment conditions.

Study II. In the second study, internship (high level) graduate students are pre-tested on the thought-listing and retrospective clinical hypothesis measures. This proceeds exactly as the above mentioned post-test in Study I, except the six-frame videotape is used. Students receive directions, view the six-frame client stimuli and thought-list in the pauses between each frame, and complete the retrospective questionnaire after viewing the entire six segments. The purpose of this study is to investigate the effects of substituting a written demonstration of the treatment content, Students assigned to the written condition are given the combination self-instruction strategy and clinical hypothesis knowledge during the pause between vignettes while observing the same six-frame videotape according to the following steps:

A. Participants receive a written demonstration of the strategy and knowledge by reading a scripted version (see Appencix G) in the pauses between each of the six videotape client stimuli statements.

B. Participants attempt to perform the written demonstrated task during the pause in response to the first six-frame videotape segment while a live instructor guides them.

C. Participants practice the task again during the pause after the second segment while instructing themselves aloud.

D. Participants perform the task during the pauses after the third and fourth frame while whispering to themselves.

E. Participants self-instruct themselves in the task covertly during the pauses after the fifth and sixth segments.

Finally, these participants are asked to apply what they just learned to a new case, the eight-frame videotape. This post-test follows the same format for the thought-listing and retrospective self-report measures as the pre-test.

Data Analysis

All respondents in the various treatment conditions will have their thought-listings assessed on elements of a clinical hypothesis based on two sets of criteria determined by expert judges and on Michenbaum's Self-Instruction Model. A score of one point will be given to a thought that expresses one of the clinical hypothesis knowledge aspects:

(1) Reflecting the major client problem (e.g., the main problem is . . .)

(2) Stating an internal or external factor (e.g., within himself he seems dissatisfied . . .)

(3) Relating the internal and external factors (e.g. maybe his self-dissatisfaction has to do with all the criticism he gets at work . . .)

(4) Differentiating or integrating cognitive, affective, or behavioral problems (e.g. she reports having a lot of negative thoughts about herself. . .)

Also, a score of one point will be given to a thought that expresses one of the self-instruction strategy aspects:

(1) Asking questions about the counseling task (e.g. what is bothering this client? . . .)

(2) Answering those questions posed (e.g. maybe the client is worried about . . .)

(3) Guiding with self-instructions (e.g. what I need to do is listen for . . .)

(4) Using coping skills (e.g. I'm confused, but I'll try again . . .)

(5) Giving self-reinforcement (e.g. I'm doing fine . . .)

Also, all respondents will have their retrospective clinical hypothesis self-report scored for accuracy on a scale from one to ten. Two expert judges viewed the eight-frame videotape and formulated clinical hypotheses whose components were highly intercorrelated. These components with the high inter-judge agreement will be the reference criteria for scoring the respondents clinical hypotheses.

Raters naive to the experimental hypotheses will be trained to analyze and score responses on the instrument. At least two raters with high inter-rater reliability will be used.

Results

Data are still being collected. When completed, we plan to analyze the data with ANOVA since there is some preliminary evidence that the dependent measures are not correlated.

On the basis of two pilot studies conducted earlier, we anticipate significant gains on both dependent variables for each of the treatment conditions in Study I.

Since there is more room for improvement on the part of low level trainees, we might expect them to profit most from the treatment. Secondly, we anticipate that exer mentation with the scoring procedure may generate differential results since clusters of scoring criteria tend to favor particular treatments. Here we would expect that multivariate analyses of the data using criteria subtest scores might generate some interesting findings in Study I.

Study Two results should be quite straight forward but we have no basis for speculating a difference between the live and written knowledge/strategy treatments. As more students become available for participation in this research, we hope to replicate this research contrast using low level, intermediate level and high level trainees in one design (3 x 2).

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APPENDICES

EIGHT FRAME STATEMENT TAPE

Client Frame 1. My boy friend asked me to marry him, but I don't know how it will turn out yet.

Client Frame 2. He thinks that I am not sincere, and I sometimes wonder if I am. He can't understand it, and I can't explain it to him. I don't know how it will work out.

Client Frame 3. I realize there are parts of things that I have to overlook and I haven't. I just feel I have to get to know him better before I can make a final decision.

Client Frame 4. We will have to spend part of the time in our home town, and that means just part of his time here at I.U. And he does have quite a few girl friends in our home town. Although I don't like the university very much, I like it better than I do home. It seems that being on campus keeps me on my toes a lot more than when I'm at home because I'm always better in an environment where I am inspired to do better.

Client Frame 5. It would probably be better if I went on with my art work. I'd be doing something that I really like. And, I don't know, I have a feeling that if you really do what you are interested in even though you fail at it, you know you're doing what you want to to. But I have set my definite aim, and that's my trouble. i can't get definite aims, what I am aiming at. I thought I'd take the course and then see where it leads.

Client Frame 6. I don't really know what I am interested in. I haven't thought about it too much . . . (long pause). I guess being around people and expressing my view points and what not, and sharing ideas.

Client Frame 7. I am considering dropping out of school at the end of this semester and returning home. I may find a contact job working in an office somewhere. It's a good paying job and doesn't require a lot of typing which I don't like, and I could have contact with people that way.

Client Frame 8. I just don't seem to have enough in back of m to have the confidence that I can do something. I did when I had a group back of me, I thought . . . well that I had lots of friends that really liked me for what I was, you know.

SIX FRAME STATEMENT TAPE

Client Frame 1. I can't find myself. Everything I do seems to be wrong. I can't get on with people. If there is any criticism or anyone says anything about me I just can't take it. When I had a job, if anyone said anything critical it just crumpled me.

Client Frame 2. It doesn't even need to be meant as criticism. It goes way back. In grade school I never felt I belonged. Oh, sometimes I would try to feel superior. I used to be the teacher's pet, but that didn't help with the other boys.

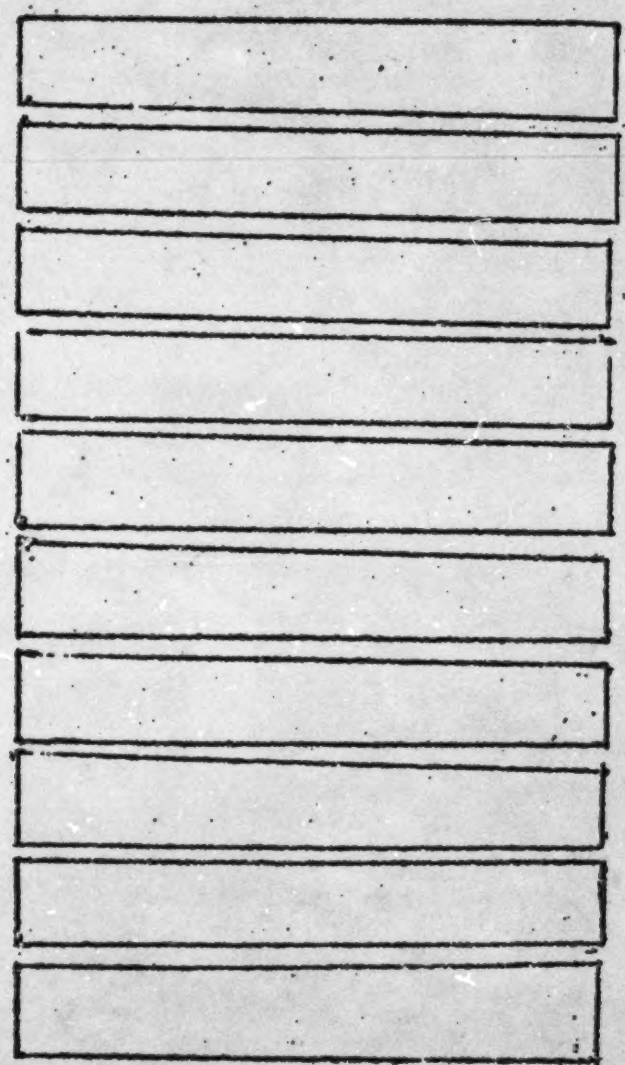
Client Frame 3. When I was with people I just didn't feel comfortable. I felt so left out of social things and things of that sort. And, well, I guess I just sorta -- when I studied it was sort of an escape for me and I tried to forget.

Client Frame 4. But I didn't study --I guess I didn't study with the right attitude to learn so I could get out of my dilemma. I sort of made it like it was a different world, my studying. I sort of secluded myself. So that my studying wasn't something that could lead me to normality and to being with people, and to having something in common with them.

Client Frame 5. Everybody else wondered why I liked to do homework and I just enjoyed it -- and it, well gave me something -- it sort of stood me up a little but I don't seem to have learned very much from it -- because, well, my memory doesn't seem to be good at all now. It's all so mixed up.

Client Frame 6. I've been mulling it over in my mind and trying to get at the bottom of it. But I don't seem to be able to. It's just such an effort for me to go around living. I know that just thinking these things isn't right. It isn't normal. It's an effort for me to walk down the street sometimes. So I just wonder what you think about me.

1. List all the thoughts you had while you were listening and observing the client.



COUNSELING QUESTIONNAIRE

Please respond to the following questions as succinctly as possible.
You have ten minutes total.

1. What is a clinical hypothesis?

2. What are the elements included in a clinical hypothesis?

3. Do you have a pattern of thinking when you are interacting with a client during a counseling interview? If you have not counseled a role play or actual client, how about when you are interacting in a significant way with another person?

2. What is (are) the client's problem(s)? What is your rationale for each stated hypothesis?

SELF-INSTRUCTION STRATEGY MODEL SCRIPT

The following is stated overtly to the subjects following each client frame.

1. The client is beginning to tell me about his problem. Now would be a good time to have a strategy to organize the information I am getting from him and to understand him. My strategy should be easy to do and follow a sequence. Let's see, how do I go about doing that? First, I need to ask myself questions about the nature of the task I am supposed to do, second to answer those questions. Third, I want to give myself positive reinforcement when I am following my strategy and finally, to be able to cope with my frustration when I make a mistake. Good, I've got a plan. I'm ready.

2. What is the nature of the task I am supposed to do? Okay, I understand. I need to listen to the client for more information and try to understand him accurately. He says everything he does is wrong and is having trouble taking criticisms. Maybe he doesn't like himself very much. Fine, I've started listening to understand him and will stay with my strategy.

3. What is the significant message here? Well, he says he feels like he doesn't belong. I am able to understand him better and what he is saying is making more sense to me now. That's good. I think I'm doing fine. Great!

4. He's telling me about his studying. How can I make the most sense from what he is saying? I'll continue to listen and stay with my strategy.

5. Now, what is he telling me? I guess he just doesn't like to be with people. No, that's not it. A lot of the problem isn't just that. O.k., try something different. . . take it easy. No need to rush it. Let's see, it could be they haven't found him interesting enough to be with. Good, I'm coping with my difficulty and frustration.

6. He wonders what I think. Good, because I have been thinking. I have used my plan and have come to know and understand him tentatively. He has been telling me a lot of negative things about himself. It seems to me he doesn't like himself. Does that sound right? Yes . . . that's it. I did my task well, including organizing what I know about him, rewarding myself, and coping. Good work. That was easy!

SELF-INSTRUCTION STRATEGY PLUS KNOWLEDGE MODEL SCRIPT

The following is stated overtly to the subjects following and client frame.

1. The client is beginning to tell me about his problem. Now would be a good time to start forming a clinical hypothesis. Let's see, how do I go about doing that? I need to have a strategy; I need to ask questions about the client's problem, answer these questions, give positive reinforcement to myself, and cope with my frustration. Besides that I need more information about the client's major problem, the significant internal and external factors, how they are related, and what parts of the problem are cognitive, affective, and behavioral. Good, I've got a plan. I'm ready.
2. What is the major theme of the client? It seems like it could be poor self-esteem. He says everything he does is wrong and is having trouble taking criticism. O.K., fine. Maybe I've identified a major problem. Now what do I need to do? I need to listen for more information about the problem and stay with my strategy, so that I will end up with an accurate clinical hypothesis.
3. What are the significant internal and external factors? Well, internally he sounds depressed, with flat affect and low energy. He also feels like he doesn't belong. Internally, he has difficulty relating to others and he escapes by studying, which increases his social isolation.
4. He's telling me more about his studying. How can I relate the internal and external factors from what he's saying? Maybe he uses the studying to build a safe environment, to protect himself from experiencing his inadequate self-concept. And yet his studies aren't fulfilling and only increase his worrying and ineffectiveness with others.

5. Now what parts of the problem are cognitive, affective, and behavioral? I guess it's mostly affective since he feels good doing homework and feels bad when he's rejected. No, that's not it. A lot of the problem isn't just affective. Okay. try something different . . . take it easy. No need to rush it. Let's see, it could be mostly cognitive, since he holds a lot of negative beliefs about himself. Some behavioral factors are also involved, since he is ineffective in forming relationships with others, and also lacks adequate coping skills.

6. He wonders what I think. Good, because I have been thinking. I used my plan and have come up with an appropriate, tentative clinical hypothesis. He has poor self-esteem, which includes feelings of depression, using studying to escape, isolating himself socially, and a history of interpersonal difficulty. Does that sound right? Uh-huh . . . that's it . . . yes . . . good work.